Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150149	A. BUILDING _____ B. WING _____	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S HOSPITAL THE	**4199 GATEWAY BLVD NEWBURGH, IN 47630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 27548 Facility Number: 002855 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - Hospital full survey June 15 -17, 2011 Date of ISDH off site review - - January 5, 2012 Reviewer/Surveyor - Billie Jo Fritch RN, PHNS Based on review of the June 15-17, 2011 HFAP Accreditation Survey Report, it has been determined that The Women's Hospital meets the requirements for Hospital Licensure in Indiana.	S 000		